



Complete Summary

GUIDELINE TITLE

Surgical treatment of pancreatic cancer.

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Surgical treatment of pancreatic cancer. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p. [5 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Pancreatic cancer

GUIDELINE CATEGORY

Diagnosis
Evaluation
Treatment

CLINICAL SPECIALTY

Gastroenterology
Oncology
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs.

TARGET POPULATION

Patients with pancreatic cancer.

INTERVENTIONS AND PRACTICES CONSIDERED

Surgical treatment of pancreatic cancer

1. Pancreaticoduodenectomy
2. Distal pancreatectomy with splenectomy
3. External beam radiation therapy combined with radiosensitizing 5-FU after pancreatic resection
4. Palliative therapy for unresectable tumors, including biliary and/or gastric bypass, endoscopic stent, radiation and chemotherapy.

MAJOR OUTCOMES CONSIDERED

- Length of hospital stay
- 5-year survival rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Please note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Treatment

In North America, less than one in five patients will have resectable tumors. Tumors in the head of the pancreas are treated by pancreaticoduodenectomy, with or without preservation of the pylorus. Preoperative or intraoperative histologic evidence of malignancy is not required to carry out resection in experienced hands. While a distal pancreatectomy with splenectomy is the procedure of choice for tumors of the body or tail of the pancreas, it is only possible in about 1 in 20 patients. External beam radiation therapy combined with radiosensitizing 5-FU (or other sensitizer) should be considered in all patients following resection.

For the majority of patients with unresectable tumors, treatment is primarily one of palliation. In patients with jaundice and gastric outlet obstruction, biliary and/or gastric bypass is indicated. At the time of surgery, a celiac plexus block with 50% alcohol may prevent or relieve pain. In the presence of jaundice alone, treatment is determined by the availability of resources. An endoscopic stent is as effective as surgical bypass, with slightly less morbidity and expense. Patients without evidence of distant metastases may benefit from external beam radiation and 5-FU or more recent regimens with a response rate in the 40% range. Patients with distant metastatic disease (Stage IV) have derived limited benefit from traditional chemotherapy but newer experimental protocols with combination drug regimens are providing improved clinical response rates.

Qualifications

At a minimum, operations for pancreatic cancer should be performed by surgeons who are certified or eligible for certification by the American Board of Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent. The qualifications of the surgeon should be based on training (education), experience, and outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Recent data suggest that patients have a 5-year survival rate of 10% to 40% following resection. With current chemotherapy or chemoradiotherapy the median survival for patients with unresectable localized disease is greater than 12 months and in patients with metastatic disease, 12 months.

POTENTIAL HARMS

The mortality rate following pancreaticoduodenectomy or distal pancreatectomy is currently less than 5% (in several large series). Significant complications following pancreatic resection occur in 5-10% of patients and include pancreatic fistula, intra-abdominal abscess, or delayed gastric emptying. Intra-abdominal or gastrointestinal bleeding, once frequent, is now uncommon, and reoperation for this complication is seldom necessary. Complication and mortality rates are similar in younger patients and in patients 70 years or older.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines have been written by the Patient Care Committee of the Society of Surgery of the Alimentary Tract (SSAT). Their goal is to guide PRIMARY CARE physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the range of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately but the reader must realize that clinical judgement may justify a course of action outside of the recommendations contained herein.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Surgical treatment of pancreatic cancer. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p. [5 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2000)

GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

GUIDELINE COMMITTEE

Patient Care Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Committee Members: Thomas R Gadacz, MD (Chairman); L William Traverso, MD; Gerald M Fried, MD; Bruce Stabile, MD; Barry A Levine, MD.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

Please note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available from the [Society for Surgery of the Alimentary Tract, Inc. Web site](#).

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 28, 2000. The information was verified by the guideline developer as of May 30, 2000.

COPYRIGHT STATEMENT

For terms governing downloading, use, and reproduction of these guidelines, please contact: ssat@prri.com.

© 1998-2004 National Guideline Clearinghouse

Date Modified: 11/15/2004

FIRSTGOV



